8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

The section hereby incorporates the terms and provisions of the federally approved Home and Community Based Supported Living Services (HCBS-SLS) Waiver, CO.0293. To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the waiver shall control.

ADDITIONS OF THE SERVICE DELIVERY OPTION OF CONSUMER ATTENDANT DIRECTED SERVICES (CDASS) TO THE HOME AND COMMUNITY BASED SERVICES-SUPPORTIVE LIVING SERVICES (HCBS-SLS) WAIVER ARE CONTINGENT UPON APPROVAL BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS). SECTIONS 8.500.94.A.10(f), 8.500.94.A.17, 8.500.94.B and 8.500.102.G SHALL NOT BE IN EFFECT UNTIL APPROVAL FROM CMS IS RECEIVED.

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HCBS-SLS services and supports which are available to assist persons with developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an HCBS-SLS setting. HCBS-SLS services are not intended to provide twenty four (24) hours of paid support or meet all identified client needs and are subject to the availability of appropriate services and supports within existing resources.

8.500.90 DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL) means basic self care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation,, and needing supervision to support behavior, medical needs and memory/cognition.

ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-SLS waiver or a specific HCBS-SLS waiver service(s).

APPLICANT means an individual who is seeking a Long Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in a assessment.

~~AUTHORIZED REPRESENTATIVE (AR) means an individual designated by the client or the legal guardian, if appropriate, who has the judgment and ability to direct Consumer Directed Attendant Support Services on the client's behalf and meets the qualifications as defined at 10 CCR 2505-10, Sections 8.510.6 and 8.510.7.~~

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CLIENT means an individual who has met Long Term Care (LTC) eligibility requirements, is enrolled in and chooses to receive LTC services, and subsequently receives LTC services.

CLIENT REPRESENTATIVE means a person who is designated by the client to act on the client's behalf. A client representative may be: (a) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or, (b) an individual, family member or friend selected by the client to speak for and/or act on the client's behalf.

COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 27-10.5105, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such

clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-105, C.R.S. *et seq*, and provides authorized services and supports to such persons either directly or by purchasing such services and supports from service agencies.

CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option DETAILED AT SECTION 8.510, ET SEQ. ~~for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care, homemaker activities.~~

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COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services, and Medicaid State Plan Benefits including Long Term Home Health services, and targeted case management.

COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the client.

DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "Developmental Disability" found in 42 U.S.C., Section 6000, *et seq*., shall not apply.

Impairment of general intellectual functioning" means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (Seventy (70) or less assuming a scale with a mean of one hundred (100) and a standard deviation of fifteen (15)), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. When an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

Adaptive behavior similar to that of a person with mental retardation means that the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

Substantial intellectual deficits means an intellectual quotient that is between seventy one (71) and seventy five (75) assuming a scale with a mean of one hundred100 and a standard deviation of fifteen (15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community ~~b~~Based Services-Supported Living Services (HCBS-SLS) to persons with developmental disabilities within the Colorado Department of Human Services.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of the Medicaid State Plan for Medicaid eligible children up to age 21.

FAMILY means a relationship as it pertains to the client and includes the following:

A mother, father, brother, sister or,

Extended blood relatives such as grandparent, aunt or uncle

Cousins or,

An adoptive parent; or,

One or more individuals to whom legal custody of a client with a developmental disability has been given by a court; or,

A spouse; or

The client's children.

~~FISCAL MANAGEMENT SERVICES ORGANIZATION (FMS) means the entity contracted with the Department as the employer of record for attendants to provide personnel management services, fiscal management services, and skills training to an authorized representative or a client receiving CDASS.~~

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FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for Long Term Care services as determined by the Department' sprescribed instrument.

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the uniform long term care instrument and medical verification on the professional medical information page to determine if the applicant or client meets the institutional level of care (LOC).

GUARDIAN means an individual at least twenty-one (21) years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated client pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute guardian but not a guardian ad litem.

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915(c) waiver of the social security act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR).

INSTITUTION means a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR) for which the Department makes Medicaid payment under the State plan.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR) means a public or private facility that provides health and habilitation services to a client with developmental disabilities or related conditions.

LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the client's spouse.

LEVEL OF CARE (LOC) means the specified minimum amount of assistance that a client must require in order to receive services in an institutional setting under the state plan. LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR), or home and community based services (HCBS), long term home health services, swing bed and hospital backup program (HBU) .

MEDICAID ELIGIBLE means an applicant or client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination.

MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the State covers, and how the State addresses additional Federal Medicaid statutory requirements concerning the operation of its Medicaid program.

MEDICATION ADMINISTRATION means assisting a client in the ingestion, application or inhalation of medication including prescription and non-prescription drugs according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

NATURAL SUPPORTS means informal relationships that provide assistance and occur in a client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

OPERATING AGENCY means the Department of Human Services, Division for Developmental Disabilities, which manages the operations of the Home and Community Based Services-for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the Home and Community Based Services for the Developmentally Disabled (HCBS-DD), Home and Community Based Services Supported Living Services (HCBS-SLS) and Home and Community Based Services Children's Extensive Support (HCBS-CES) waivers.

POST ELIGIBILITY TREATMENT OF INCOME (PETI) means the determination of the financial liability of an HCBS waiver client as defined in 42 C.F.R 435.217.

PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, the Operating Agency, a State fiscal agent or the case management agency.

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client needs institutional level of care.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in 2 CCR 503-1, Section 16.200 *et seq.*,, that has received program approval to provide HCBS-SLS services.

PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use including vehicles for hire.

Reimbursement rates means the maximum allowable Medicaid reimbursement to a provider for each unit of service.

RELATIVE means a person related to the client by virtue of blood, marriage, adoption or common law marriage.

RETROSPECTIVE REVIEW means the Department or the Operating Agency's review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service

~~Service Delivery Option~~SERVICE DELIVERY OPTION means the method by which direct services are provided to a participant. Those options include: A) Agency Based in which the agency has the employer and budget authority, B) Participant Directed in which the participant has the employer and budget authority for specified services.

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SERVICE PLAN means the written document that specifies identified and needed services to include Medicaid eligible and non-Medicaid eligible services, regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the Department and the Operating Agency' pertain set forth in 10 CCR 2505-10, Section 8.400.

SERVICE PLAN AUTHORIZATION LIMIT (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the client's ongoing needs. Each SPAL is determined by the Department and Operating Agency based on the annual appropriation for the HCBS-SLS waiver, the number of clients in each level, and projected utilization.

SUPPORT is any task performed for the client where learning is secondary or incidental to the task itself or an adaptation is provided.

SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

"SUPPORT LEVEL" means a numeric value determined using an algorithm that places clients into groups with other clients who have similar overall support needs. ~~MEANS A NUMERIC VALUE DETERMINED USING AN ALGORITHM THAT PLACES CLIENTS INTO GROUPS WITH OTHER CLIENTS WHO HAVE SIMILAR OVERALL SUPPORT NEEDS.~~

TARGETED CASE MANAGEMENT (TCM) means a Medicaid State plan benefit for a target population which includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources such as medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources.

THIRD PARTY RESOURCES means services and supports that a client may receive from a variety of programs and funding sources beyond natural supports or Medicaid that may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

WAIVER SERVICE means optional services defined in the current federally approved waiver documents and do not include Medicaid State plan benefits.

8.500.91 HCBS-SLS WAIVER ADMINISTRATION

8.500.91.A HCBS-SLS shall be provided in accordance with the federally approved waiver document and these rules and regulations, and the rules and regulations of the Colorado Department of Human Services, Division for Developmental Disabilities, 2 CCR 503-1 and promulgated in accordance with the provision of Section 25.5-6-404(4), C.R.S.

8.500.91.B In the event a direct conflict arises between the rules and regulations of the Department and the Operating Agency, the provisions of Section 25.5-6-404(4), C.R.S. shall apply and the regulations of the Department shall control.

8.500.10.C The HCBS-SLS Waiver is operated by the Department of Human Services, Division for Developmental Disabilities under the oversight of the Department of Health Care Policy and Financing ~~HEALTH CARE POLICY AND FINANCING. Human Services, Division for~~ INTELLECTUAL AND ~~Developmental Disabilities.~~

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~~under the oversight of the Department of Health Care Policy and Financing.~~

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8.500.910.E HCBS-SLS services are available only to address those needs identified in the functional needs assessment and authorized in the service plan when the service or support is not available through the Medicaid State plan, EPSDT, natural supports, or third party payment resources.

8.500.91.F The HCBS-SLS Waiver:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments into the HCBS-SLS Waiver do not exceed the federally approved waiver capacity, and

4. May limit the enrollment when utilization of the HCBS-SLS Waiver program is projected to exceed the spending authority.

8.500.92 GENERAL PROVISIONS

8.500.92.A The following provisions shall apply to the Home and Community Based Services-Supported Living Services (HCBS-SLS) Waiver:

1. HCBS-SLS shall be provided as an alternative to ICF-MR services for an eligible client with developmental disabilities.

2. HCBS-SLS is waived from the requirements of Section 1902(a)(10)(b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the State of Colorado.

3. A client enrolled in the HCBS-SLS Waiver shall be eligible for all other Medicaid services for which the client qualifies and shall first access all benefits available under the Medicaid State plan or Medicaid EPSDT prior to accessing services under the HCBS-SLS Waiver. Services received through the HCBS-SLS Waiver may not duplicate services available through the State Plan

8.500.93 CLIENT ELIGIBILITY

8.500.93.A To be eligible for the HCBS-SLS Waiver an individual shall meet the target population criteria as follows:

1. Be determined to have a~~n intellectual/~~developmental disability

2. Be eighteen (18) years of age or older,

3. Does not require twenty-four (24) hour supervision on a continuous basis which is reimbursed as a HCBS-SLS service,

4. Is served safely in the community with the type or amount of HCBS-SLS waiver services available and within the federally approved capacity and cost containment limits of the waiver,

5. Meet ICF-MR level of care as determined by the Functional Needs Assessment

6. Meet the Medicaid financial determination for LTC eligibility as specified at 10 CCR 2505-10, Section 8.100 *et seq.* ; and,

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7. Reside in an eligible HCBS-SLS setting. SLS settings are the client's residence, which is defined as the following:

   a. A living arrangement, which the client owns, rents or leases in own name,

   b. The home where the client lives with the client's family or legal guardian, or

   c. A living arrangement of no more than three (3) persons receiving HCBS-SLS residing in one household, unless they are all members of the same family.

8. The client shall maintain eligibility by continuing to meet the HCBS-SLS eligibility requirements and the following:

   a. Receives at least one (1) HCB-SLS waiver service each calendar month,

   b. Is not simultaneously enrolled in any other HCBS waiver, and

   c. Is not residing in a hospital, nursing facility, ICF-MR, correctional facility or other institution.

9. When the HCBS-SLS waiver reaches capacity for enrollment, a client determined eligible for a waiver shall be placed on a wait list in accordance with these rules.10 CCR 2505-10, Section 8.500.96 et seq.

8.500.94 HCBS-SLS WAIVER SERVICES

8.500.94.A The following services are available through the HCBS-SLS Waiver within the specific limitations as set forth in the federally approved HCBS-SLS Waiver.

1. Assistive technology includes services, supports or devices that assist a client to increase, maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes:

   a. The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client,

   b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,

   c. Training or technical assistance for the client, or where appropriate, the family members, guardians, caregivers, advocates, or authorized representatives of the client,

d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-SLS Waiver, and

e. Adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency procedure.

f. Assistive technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid state plan or third party resource.

g. Assistive technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.

h. When the expected cost is to exceed $2,500 per device three estimates shall be obtained and maintained in the case record.

i. Training and technical assistance shall be time limited, goal specific and outcome focused.

j. The following items and services are specifically excluded under HCBS-SLS waiver and not eligible for reimbursement:

   i) Purchase, training or maintenance of service animals,

   ii) Computers,

   iii) Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of game,

   iv) Training or adaptation directly related to a school or home educational goal or curriculum.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five year life of the waiver unless an exception is applied for and approved. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Operating Agency's procedures within thirty (30) days of the request.

2. Behavioral services are services related to the client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.

a. Behavioral services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.

b. A client with a co-occurring diagnosis of a developmental disability and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.

c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.

d. Behavioral Services:

i) Behavioral consultation services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management.

ii) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service shall be established.

iii). Behavioral consultation services are limited to eighty (80) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

v) Behavioral plan assessment services are limited to forty (40) units and one (1) assessment per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

vi) Individual or group counseling services include psychotherapeutic or psychoeducational intervention that:

1) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

2) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.

3) Counseling services are limited to two hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

vii) Behavioral line services include direct one on one (1:1) implementation of the behavioral support plan and are:

1) Under the supervision and oversight of a behavioral consultant,

2) To include acute, short term intervention at the time of enrollment from an institutional setting, or

3) To address an identified challenging behavior of a client at risk of institutional placement, and that places the client's health and safety or the safety of others at risk

4) Behavioral line services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. All behavioral line services shall be prior authorized in accordance with Operating Agency procedure

3. Day habilitation services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs.

a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.

b. Day habilitation services and supports encompass three (3) types of habilitative environments-; specialized habilitation services, supported community connections, and prevocational services.

c. Specialized habilitation (SH) services are provided to enable the client to attain the maximum functional level or to be supported in such a manner that allows the client to gain an increased level of self-sufficiency. Specialized habilitation services:

i) Are provided in a non-integrated setting where a majority of the clients have a disability,

ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and

iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.

d. Supported community connections services are provided to support the abilities and skills necessary to enable the client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:

i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a client's service plan,

ii) Are conducted in a variety of settings in which the client interacts with persons without disabilities other than those individuals who are providing services to the client. These types of services may include socialization, adaptive skills and personnel to accompany and support the client in community settings,

iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and

iv) May be provided in a group setting or may be provided to a single client in a learning environment to provide instruction when identified in the service plan.

v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

e. Prevocational services are provided to prepare a client for paid community employment. Services include teaching concepts including attendance, task completion, problem solving and safety and are associated with performing compensated work.

i) Prevocational services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.

ii) Goals for prevocational services are to increase general employment skills and are not primarily directed at teaching job specific skills.

iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than 50 percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor regulations.

iv) Prevocational services are provided to support the client to obtain paid community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need based on an annual assessment.

v) A comprehensive assessment and review for each person receiving prevocational services shall occur at least once every five years to determine whether or not the person has developed the skills necessary for paid community employment.

vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under section 110 of the rehabilitation act of 1973 or the Individuals with Educational Disabilities Act (20 U.S.C. Section 1401 *et seq*).

f. Day habilitation services are limited to seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

g. The number of units available for day habilitation services in combination with prevocational services and supported employment shall not exceed seven thousand one hundred and twelve (7,112) units.

4. Dental services are available to individuals age twenty one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

a. Preventative services include:

i) Dental insurance premiums and co-payments

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv) Non-intravenous sedation,

v) Basic and deep cleanings,

vi) Mouth guards,

vii) Topical fluoride treatment,

ix)

xi) Retention or recovery of space between teeth when indicated, and

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

v) Non-emergency extractions including simple, surgical, full and partial,

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth,

c. Major services include:

i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.

ii) Crowns

iii) Bridges

iv) Dentures

d. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10, 8011.11 or available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most

cost effective and efficient means to alleviate or rectify the dental issue associated with the client

e. Implants shall not be a benefit for clients who use tobacco daily due to substantiated increased rate of implant failures for chronic tobacco users.

f. Subsequent implants are not a covered service when prior implants fail.

g. Full mouth implants or crowns are not covered.

h. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodotic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

i. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

j. Preventative and basic services are limited to two thousand ($2,000) per service plan year. Major services are limited to ten thousand ($10,000) for the five (5) year renewal period of the waiver.

5. Home Accessibility Adaptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health, and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include:

a. The installation of ramps,

b. Widening or modification of doorways,

c. Modification of bathroom facilities to allow accessibility and assist with needs in activities of daily living,

d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment supplies that are necessary for the welfare of the client, and

e. Safety enhancing supports such as basic fences, door and window alarms.

f. The following items are specifically excluded from home accessibility adaptations and shall not be reimbursed:

i) Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability,

ii) Carpeting,

iii) Roof repair,

iv). Central air conditioning,

v) Air duct cleaning,

vi) Whole house humidifiers,

vii) Whole house air purifiers,

viii) Installation or repair of driveways and sidewalks,

ix) Monthly or ongoing home security monitoring fees,

x) Home furnishings of any type, and

xii) Luxury upgrades.

g. When the HCBS-SLS waiver has provided modifications to the client's home and the client moves to another home, those modifications shall not be duplicated in the new residence unless prior authorized in accordance with Operating Agency procedures.

Adaptation to rental units, when the adaptation is not portable and cannot move with the client shall not be covered unless prior authorized in accordance with Operating Agency procedures.

h. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

i. improve entrance or egress to a residence; or,

ii. configure a bathroom to accommodate a wheelchair.

i. Any request to add square footage to the home shall be prior authorized in accordance with Operating Agency procedures.

j. All devices and adaptations shall be provided in accordance with applicable state or local building codes or applicable standards of

manufacturing, design and installation. Medicaid state plan, EPSDT or third party resources shall be utilized prior to authorization of waiver services.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five-year life of the waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health, and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with Operating Agency procedure.

6. Homemaker services are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of homemaker services:

a. Basic homemaker services include cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents.

i) Assistance may take the form of hands-on assistance including actually performing a task for the client or cueing to prompt the client to perform a task.

ii) Lawn care, snow removal, air duct cleaning, and animal care are specifically excluded under the HCBS-SLS waiver and shall not be reimbursed.

b. Enhanced homemaker services includes basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning

i) Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing.

ii) The provider shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task.

1) When such support is incidental to the habilitative services being provided, and

2) To increase the independence of the client,

iii) Incidental basic homemaker service may be provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the client.

iv) Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.

7. Mentorship services are provided to clients to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising and include:

a. Assistance in interviewing potential providers,

b. Assistance in understanding complicated health and safety issues,

c. Assistance with participation on private and public boards, advisory groups and commissions, and

d. Training in child and infant care for clients who are parenting children.

e. Mentorship services shall not duplicate case management or other HCBS-SLS waiver services.

f. Mentorship services are limited to one hundred and ninety two (192) units (forty eight (48) hours) per service plan year. One (1) unit is equal to fifteen (15) minutes.

g. Units to provide training to clients for child and infant care shall be prior authorized beyond the one hundred and ninety two (192) units per service plan year in accordance with Operating Agency procedures.

8. Non-medical transportation services enable clients to gain access to day habilitation, prevocational and supported employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band.

a. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized and documented in the service plan.

b. Non-medical transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-medical transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip charge assessed each way to and from day habilitation and supported employment services.

c. Transportation provided to destinations other than to day program or supported employment is limited to four (4) trips per week reimbursed at mileage band one

d. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. the applicable mileage band. Non-medical traMedicaid State Plan, defined at 42 C.F.R. §440.170(A).

9. Personal Emergency Response System (PERS) is an electronic device that enables clients to secure help in an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to a signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

a. The client and the client's case manager shall develop a protocol for identifying who should to be contacted if the system is activated.

10. Personal Care is assistance to enable a client to accomplish tasks that the client would complete without assistance if the client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task. Personal care services include:

a. Assistance with basic self care including hygiene, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.

b. Assistance with money management,

c. Assistance with menu planning and grocery shopping, and

d. Assistance with health related services including first aide; medication administration; assistance scheduling or reminders to attend routine or as needed medical, dental and therapy appointments; support that may include accompanying clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, ~~or skilled care that takes place out of the home.~~ [THAT TAKE PLACE OUT OF THE HOME.]

e. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be covered to the extent the Medicaid state plan or third party resource does not cover the service.

f. If the annual functional needs assessment identifies a possible need for skilled care: ~~then the client shall obtain a home health assessment.~~

i) THE CLIENT SHALL OBTAIN A HOME HEALTH ASSESSMENT, OR

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Commented [DT1]: This sentence still didn't work, and I think "out of the home" is explicit in the phrase "accompanying clients to. . ." I think it's best just to leave it off. I also added semicolons to clarify the items which are in a list within a broader list.

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ii) THE CLIENT SHALL BE INFORMED OF THE OPTION TO DIRECT HIS/HER HEALTH MAINTENANCE ACTIVITIES PURSUANT TO SECTION 8.500.~~108.F~~94.B.

11. Professional services are provided by licensed, certified, registered or accredited professionals and the intervention is related to an identified medical or behavioral need. Professional services include:

    a. Hippotherapy includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.

    b. Movement therapy includes the use of music or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.

    c. Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes watsu.

    d. Professional services can be reimbursed only when:

        i) The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession,

        ii) The intervention is related to an identified medical or behavioral need, and

        iii) The Medicaid State plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

    e. A pass to community recreation centers shall only be used to access professional services and when purchased in the most cost effective manner including day passes or monthly passes.

    f. The following services are excluded under the HCBS Waiver from reimbursement;

        i) Acupuncture,

        ii) Chiropractic care,

        iii) Fitness trainer

        iv) Equine therapy,

v) Art therapy,

vi) Warm water therapy,

viii) Experimental treatments or therapies, and.

ix) Yoga.

12. Respite service is provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client.

a. Respite may be provided:

i) In the client's home and private place of residence,

ii) The private residence of a respite care provider, or

iii) In the community.

b. Respite shall be provided according to individual or group rates as defined below:

i) Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period.

ii) Individual Day: the client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period.

iii) Overnight Group: the client receives respite in a setting which is defined as a facility that offers 24 hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.

iv) Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate.

c. The following limitations to respite services shall apply:

i) Federal financial participation shall not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to 2 CCR 503-1, Section 16.221. by the state that is not a private residence.

ii) Overnight group respite may not substitute for other services provided by the provider such as personal care, behavioral services or services not covered by the HCBS-SLS Waiver.

iii) Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight group respite rate shall not exceed the respite daily rate.

13. Specialized Medical Equipment and Supplies include: devices, controls, or appliances that are required due to the client's disability and that enable the client to increase the client's ability to perform activities of daily living or to safely remain in the home and community. Specialized medical equipment and supplies include:

a. kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;

b. specially designed clothing for a client if the cost is over and above the costs generally incurred for a client's clothing;

c. maintenance and upkeep of specialized medical equipment purchased through the HCBS-SLS waiver.

d. The following items are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement:

i) Items that are not of direct medical or remedial benefit to the client are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement. These include but are not limited to; vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.

14. Supported Employment services includes intensive, ongoing supports that enable a client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the client's disabilities needs supports to perform in a regular work setting.

a. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development, and assisting the client to locate a job or job development on behalf of the client.

b. Supported employment may be delivered in a variety of settings in which clients interact with individuals without disabilities, other than those individuals who are providing services to the client, to the same extent

that individuals without disabilities employed in comparable positions would interact.

c. Supported employment is work outside of a facility-based site, that is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities,

d. Supported employment is provided in community jobs, enclaves or mobile crews.

e. Group employment including mobile crews or enclaves shall not exceed eight clients.

f. Supported employment includes activities needed to sustain paid work by clients including supervision and training.

g. When supported employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a client as a result of the client's disabilities.

h. Documentation of the client's application for services through the Colorado Department of Human Services Division for Vocational Rehabilitation shall be maintained in the file of each client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. § 1401et seq).

i. Supported employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.

j. Supported employment shall not take the place of nor shall it duplicate services received through the Division for Vocational Rehabilitation.

k. The limitation for supported employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

l. The following are not a benefit of supported employment and shall not be reimbursed:

   i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,

   ii) Payments that are distributed to users of supported employment, and

iii) Payments for training that are not directly related to a client's supported employment.

15. Vehicle modifications are adaptations or alterations to an automobile or van that is the client's primary means of transportation; to accommodate the special needs of the client; are necessary to enable the client to integrate more fully into the community; and to ensure the health and safety of the client.

a. Upkeep and maintenance of the modifications are allowable services.

b. Items and services specifically excluded from reimbursement under the HCBS Waiver include:

i) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the client,

ii) Purchase or lease of a vehicle, and

iii) Typical and regularly scheduled upkeep and maintenance of a vehicle.

c. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five (5) year life of the HCBS Waiver except that on a case by case basis the Operating Agency may approve a higher amount. Such requests shall ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-SLS Waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no duplication.

16. Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a client who is at least 21 years of age

a. Lasik and other similar types of procedures are only allowable when:

b. The procedure is necessary due to the client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective, and

c. Prior authorized in accordance with Operating Agency procedures.

17. HEALTH MAINTENANCE ACTIVITIES ARE ~~ONLY~~ AVAILABLE ONLY AS A PARTICIPANT DIRECTED SUPPORTED LIVING SERVICES~~.~~ IN ACCORDANCE WITH 8.500.94.B109. HEALTH MAINTENANCE ACTIVITIES. ROUTINE AND REPETITIVE HEALTH RELATED TASKS FURNISHED TO AN ELIGIBLE CLIENT IN THE COMMUNITY OR IN THE CLIENT'S HOME, WHICH

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ARE NECESSARY FOR HEALTH AND NORMAL BODILY FUNCTIONING THAT A PERSON WITH A DISABILITY IS UNABLE TO PHYSICALLY CARRY OUT. SERVICES MAY INCLUDE:

a. SKIN CARE PROVIDED WHEN THE SKIN IS BROKEN OR A CHRONIC SKIN CONDITION IS ACTIVE AND COULD POTENTIALLY CAUSE INFECTION. SKIN CARE MAY INCLUDE: WOUND CARE, DRESSING CHANGES, APPLICATION OF PRESCRIPTION MEDICINE, AND FOOT CARE FOR PEOPLE WITH DIABETES WHEN PRESCRIBED BY A LICENSED MEDICAL PROFESSIONAL

b. NAIL CARE IN THE PRESENCE OF MEDICAL CONDITIONS THAT MAY INVOLVE PERIPHERAL CIRCULATORY PROBLEMS OR LOSS OF SENSATION

c. MOUTH CARE PERFORMED WHEN:

i) THERE IS INJURY OR DISEASE OF THE FACE, MOUTH, HEAD OR NECK

ii) IN THE PRESENCE OF COMMUNICABLE DISEASE0

iii) THE CLIENT IS UNCONSCIOUS

iv) ORAL SUCTIONING IS REQUIRED

d. DRESSING, INCLUDING THE APPLICATION OF ANTI-EMBOLIC OR OTHER PRESCRIPTION PRESSURE STOCKINGS AND ORTHOPEDIC DEVICES SUCH AS SPLINTS, BRACES, OR ARTIFICIAL LIMBS IF CONSIDERABLE MANIPULATION IS NECESSARY

e. FEEDING

i) WHEN ORAL SUCTIONING IS NEEDED ON A STAND-BY OR OTHER BASIS

ii) WHEN THERE IS HIGH RISK OF CHOKING THAT COULD RESULT IN THE NEED FOR EMERGENCY MEASURES SUCH AS CPR OR THE HEIMLICH MANEUVER AS DEMONSTRATED BY A SWALLOW STUDY

iii) SYRINGE FEEDING

iv) FEEDING USING APPARATUS

f. EXERCISE PRESCRIBED BY A LICENSED MEDICAL PROFESSIONAL INCLUDING PASSIVE RANGE OF MOTION

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g. TRANSFERRING A CLIENT WHEN HE/SHE IS UNABLE TO ASSIST OR THE USE OF A LIFT SUCH AS A HOYER IS NEEDED

h. BOWEL CARE PROVIDED TO A CLIENT INCLUDING DIGITAL STIMULATION, ENEMAS, CARE OF OSTOMIES, AND INSERTION OF A SUPPOSITORY IF THE CLIENT IS UNABLE TO ASSIST

i. BLADDER CARE WHEN IT INVOLVES DISRUPTION OF THE CLOSED SYSTEM FOR A FOLEY OR SUPRAPUBIC CATHETER, SUCH AS CHANGING FROM A LEG BAG TO A NIGHT BAG AND CARE OF EXTERNAL CATHETERS

j. MEDICAL MANAGEMENT REQUIRED BY A MEDICAL PROFESSIONAL TO MONITOR: BLOOD PRESSURES, PULSES, RESPIRATORY ASSESSMENT, BLOOD SUGARS, OXYGEN SATURATIONS, PAIN MANAGEMENT, INTRAVENOUS, OR INTRAMUSCULAR INJECTIONS

k. RESPIRATORY CARE:

I) POSTURAL DRAINAGE

ii) CUPPING

iii) ADJUSTING OXYGEN FLOW WITHIN ESTABLISHED PARAMETERS

iv) SUCTIONING OF MOUTH AND NOSE

vi) VENTILATOR AND TRACHEOSTOMY CARE

vii) PRESCRIBED RESPIRATORY EQUIPMENT

v) NEBULIZERS

8.500.94.B PARTICIPANT-DIRECTED SUPPORTED LIVING SERVICES

PARTICIPANT DIRECTION OF HCBS-SLS WAIVER SERVICES IS AUTHORIZED PURSUANT TO THE PROVISIONS OF THE FEDERALLY APPROVED HOME AND COMMUNITY BASED SUPPORTED LIVING SERVICES (HCBS-SLS) WAIVER, CO.0293 AND C.R.S. 25.5-6-1101, ET SEQ. (2014).

1. PARTICIPANTS MAY CHOOSE TO DIRECT THEIR OWN SERVICES THROUGH THE CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES DELIVERY OPTION DETAILED AT SECTION 8.510, ET SEQ. SERVICES THAT MAY BE PARTICIPANT-DIRECTED UNDER THIS OPTION ARE AS FOLLOWS:

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i) PERSONAL CARE AS DEFINED AT SECTION 10 CCR 2505-10 §8.500.94.A.10

ii) HOMEMAKER AS DEFINED AT SECTION 10 CCR 2505-10 §8.500.94.A.6

iii) HEALTH MAINTENANCE ACTIVITIES AS DEFINED AT SECTION 10 CCR 2505-10 §8.500.94.A.17

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8.500.95 SERVICE PLAN:

8.500.95.A The case management agency shall complete a service plan for each client enrolled in the HCBS Waiver in accordance with 10 CCR 2505-10, Section 8.400.

8.500.95.B The service plan shall:

1. Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver services or through other means,

2. Be in accordance with the Department's rules, policies and procedures, and

3. Include updates and revisions at least annually or when warranted by changes in the client's needs.

8.500.95.C The service plan shall document that the client has been offered a choice:

1. Between waiver services and institutional care,

2. Among waiver services, and

3. Among qualified providers.

8.500.96 WAITING LIST PROTOCOL

8.500.96.A When the federally approved waiver capacity has been met, persons determined eligible to receive services under the HCBS-SLS, shall be eligible for placement on a waiting list for services.

8.500.96.B Waiting lists for persons eligible for the HCBS-SLS waiver program shall be administered by the Community Centered Boards, uniformly administered throughout the State and in accordance with these rules and the Operating Agency's procedures .

8.500.96.C Persons determined eligible shall be placed on the waiting list for services in the Community Centered Board service area of residency.

8.500.96.D Persons who indicate a serious intent to move to another service area should services become available shall be placed on the waiting list in that service area.

Placement on a waiting list in a service area other than the area of residency shall be in accordance with criteria established in the Operating Agency's procedures for placement on a waiting list in a service area other than the area of residency.

8.500.96.E The date used to establish a person's placement on a waiting list shall be:

1. The date on which eligibility for developmental disabilities services in Colorado was originally determined; or

2. The fourteenth (14th) birth date if a child is determined eligible prior to the age of fourteen and is waiting for adult services.

8.500.96.F As openings become available in the HCBS-SLS waiver program in a designated service area, persons shall be considered for services in order of placement on the local Community Centered Board's waiting list and with regard to an appropriate match to services and supports. Exceptions to this requirement shall be limited to:

1. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered and the emergency cannot be resolved in another way. Emergencies are defined as follows:

   a. Homeless: the person does not have a place to live or is in imminent danger of losing his/her place of abode.

   b. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.

   c. Danger to Others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

   d. Danger to Self: a person's medical, psychiatric or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.

   e. The Legislature has appropriated funds specific to individuals or to a specific class of persons.

   f.. If an eligible individual is placed on a waiting list for SLS waiver services, a written notice, including information regarding the client appeals process, shall be sent to the individual and/or his/her legal guardian in accordance with the provisions of Section 8.057, *et seq*. .

8.500.97 CLIENT RESPONSIBILITIES

8.500.97.A A client or the client's family or guardian is responsible for:

1. Providing accurate information regarding the client's ability to complete activities of daily living,

2. Assisting in promoting the client's independence,

~~3.~~

3~~4~~. Cooperating in the determination of financial eligibility,

4~~5~~. Notifying the case manager within thirty (30) days after:

a. Changes in the client's support system, medical condition and living situation including any hospitalizations, emergency room admissions,

b. Placement to a nursing home or intermediate care facility for the mentally retarded (ICF-MR),

c. The client has not received an HCBS waiver service during one (1) month

d. Changes in the client's care needs,

e. Problems with receiving HCBS-SLS waiver services, and

f. Changes that may affect Medicaid financial eligibility including prompt report of changes in income or assets.

8.500.98 PROVIDER REQUIREMENTS

8.500.98.A A private for profit or not for profit agency or government agency shall meet minimum provider qualifications as set forth in the HCBS-SLS waiver and shall:,

1. Conform to all state established standards for the specific services they provide under HCBS-SLS,

2. Maintain program approval and certification from the Operating Agency,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in 10 CCR 2505-10, Section 8.130,

4. Discontinue HCBS-SLS services to a client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

5. Have written policies governing access to duplication and dissemination of information from the client's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S., as amended,

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6. When applicable, maintain the required licenses from the Colorado Department of Public Health And Environment, and

7. Maintain client records to substantiate claims for reimbursement according to Medicaid standards.

8.500.98.B HCBS-SLS providers shall comply with:

1. All applicable provisions of 27, 10.5, C.R.S. et seq, and the rules and regulations as set forth in 2 CCR 503-1, 16.100 *et seq*.,:

2. All federal program reviews and financial audits of the HCBS-SLS waiver services,

3. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits,

4.

5. Requests from the county Departments of Social/Human Services to access records of clients receiving services held by case management agencies as required to determine and re-determine Medicaid eligibility;,

6. Requests by the Department or the Operating Agency to collect, review and maintain individual or agency information on the HCBS-SLS waiver, and

7. Requests by the case management agency to monitor service delivery through targeted case management activities.

8.500.99 TERMINATION OR DENIAL OF HCBS-SLS MEDICAID PROVIDER AGREEMENTS

8.500.99.A The Department may deny or terminate an HCBS-SLS Medicaid provider agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at 10 CCR 2505-10, Section 8.130 *et seq*,

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-SLS services,

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider,

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper client notification,

5. Emergency termination of any provider agreement shall be in accordance with procedures at 10 CCR 2505-10, section 8.050, and

8.500.99.B The provider fails to comply with requirements for submission of claims pursuant to 10 CCR 2505-10, Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

8.500.100 ORGANIZED HEALTH CARE DELIVERY SYSTEM

8.500.100.A The Organized Health Care Delivery System (OHCDS) for the HCBS-SLS waiver is the Community Centered Board as designated by the Operating Agency in accordance with § 27-1010.5-103,.

8.500.100.B The OHCDS is the Medicaid provider of record for a client whose services are delivered through the OHCDS,

8.500.100.C The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS according to the current federally approved waiver.

8.500.100.D The OHCDS may contract or employ for delivery of HCBS Waiver services.

8.500.100.E The OCHDS shall:

1. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS Waiver,

2. Ensure that services are delivered according to the waiver definitions and as identified in the client's service plan,

3. Ensure the contractor maintains sufficient documentation to support the claims submitted, and

4. Monitor the health and safety for HCBS clients receiving services from a subcontractor.

8.500.100.F The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to clients,

4. Negotiate rates that are in accordance with the Operating Agency's established fee for service rate schedule and Operating Agency procedures,

   a. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a manufacturer's suggested retail price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

5. Collect and maintain the data used to develop provider rates and ensure data includes costs for services to address the client's needs, that are allowable activities within the HCBS service definition and that supports the established rate,

6. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency or Centers for Medicare and Medicaid Services (CMS), and

7. Report by August 31 of each year, the names, rates and total payment made to the contractor.

8.500.101 PRIOR AUTHORIZATION REQUESTS

8.500.101.A Prior authorization requests (PAR) shall be in accordance with 10 C.C.R. 2505-10, Section 8.058.

8.500.101.B A prior authorization request shall be submitted to the Operating Agency through the Department's designated information management system.

8.500.101.C The case management agency shall comply with the policies and procedures for the PAR review process as set forth by the Department or the Operating Agency.

8.500.101.D The case management agency shall submit the PAR in compliance with all applicable regulations and ensure requested services are:

1. Consistent with the client's documented medical condition and functional capacity as indicated in the functional needs assessment,

2. Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved waiver, and

3. Not duplicative of another authorized service, including services provided through:

a. Medicaid State plan benefits,

b. Third party resources,

c. Natural supports,

d. Charitable organizations, or

e. Other public assistance programs.

4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10 § 8.058.4.

8.500.102 SERVICE PLAN AUTHORIZATION LIMITS (SPAL)

8.500.102.A The service plan authorization limit (SPAL) sets an upper payment limit of total funds available to purchase services to meet a client's ongoing service needs within one (1) service plan year.

8.500.102.B The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations and vehicle modifications.

8.500.102.C The total of all HCBS-SLS services in one service plan shall not exceed the overall authorization limitation as set forth in the federally approved HCBS-SLS waiver.

8.500.102.D Each SPAL is assigned a specific dollar amount determined through an analysis of historical utilization of authorized waiver services, total reimbursement for services, and the spending authority for the HCBS-SLS waiver. Adjustments to the SPAL amount may be determined by the Department and Operating Agency as necessary to manage waiver costs.

8.500.102.E Each SPAL is associated with six support levels determined by an algorithm which analyzes a client's level of service need as determined by the SIS assessment and additional factors including exceptional medical and behavioral support needs and identification as a community safety risk.

8.500.102.F The SPAL determination shall be implemented in a uniform manner statewide and the SPAL amount is not subject to appeal.

8.500.102.G HEALTH MAINTENANCE ACTIVITIES AVAILABLE UNDER PARTICIPANT DIRECTED SERVICES IS NOT SUBJECT TO THE SERVICE PLAN AUTHORIZATION LIMIT OR THE WAIVER CAP.

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8.500.103 RETROSPECTIVE REVIEW PROCESS

8.500.103.A Services provided to a client are subject to a retrospective review by the Department and the Operating Agency. This retrospective review shall ensure that services:

1. Identified in the service plan are based on the client's identified needs as stated in the functional needs assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a client are in accordance with the service plan, and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-SLS waiver,

8.500.103.B When the retrospective review identifies areas of non compliance, the case management agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.103.C The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.500.103.D When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status

8.500.104 PROVIDER REIMBURSEMENT

8.500.104.A Providers shall submit claims directly to the Department's fiscal agent through the Medicaid management information system (MMIS); or through a qualified billing agent enrolled with the Department's fiscal agent.

8.500.104.B Provider claims for reimbursement shall be made only when the following conditions are met:

1. Services are provided by a qualified provider as specified in the federally approved HCBS-SLS waiver,

2. Services have been prior authorized,

3. Services are delivered in accordance with the frequency, amount, scope and duration of the service as identified in the client's service plan, and

4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.104.C Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.

8.500.104.D When the review identifies areas of non compliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.104.E When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claim submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.104.F Except where otherwise noted, payment is based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the provider bulletin accessed through the Department's fiscal agent's web site.

8.500.105 INDIVIDUAL RIGHTS

8.500.105.A The rights of a client in the HCBS-SLS Waiver shall be in accordance with Sections 27-10.5-112 through 131, C.R.S.

8.500.106 APPEAL RIGHTS

8.500.106.A The CCB shall provide the long term care notice of action form to applicants and clients within ten (10) business days regarding their appeal rights in accordance with 10 CCR 2505-10, Section 8.057 *et seq*. When:

1. The applicant is determined to not have a developmental disability,

2. The applicant is found eligible or ineligible for LTC services,

3. The applicant is determined eligible or ineligible for placement on a waitlist for Medicaid LTC services,

4. An adverse action occurs that affects the client's waiver enrollment status,

5. An adverse action occurs that affects the provision of the client's waiver services, or

6. The applicant or client requests such information.

8.500.106.B The CCB shall represent their decision at the office of administrative courts as described in 10 CCR 2505-10, Section 8.057 *et seq* when CCB has made a denial or adverse action against a client.

8.500.106.C The CCB shall notify all providers in the client's service plan within ten (10) business day of the adverse action.

8.500.106.D The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.

8.500.106.E The applicant or client shall be informed of an adverse action if the client is determined ineligible as set forth in client eligibility and the following:

1. The client cannot be served safely within the cost containment as identified in the HCBS-SLS Waiver,

2. The client is placed in an institution for treatment with a duration that continues for more than thirty (30) days,

3. The client is detained or resides in a correctional facility, or

4. The client enters an institute for mental health with a duration that continues for more than thirty (30) days.

8.500.106.F The client shall be notified, pursuant to 10 CCR 2505-10, Section 8.057.2.A, when the following results in an adverse action that does not relate to HCBS-SLS waiver client eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the functional needs assessment,

2. A waiver service is terminated or denied because is not available through the current federally approved waiver,

3. A service plan or waiver service exceeds the limits as set forth in the in the federally approved waiver,

4. The client or client representative has failed to schedule an appointment for the functional needs assessment, service plan, or six (6) month visit with the case manager two (2) times in a thirty (30) day consecutive period,

5. The client or client representative has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,

6. The client enrolls in a different long term care program, or

7. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.

a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to income maintenance staff manual 9 CCR 2503-1, Section 3.140.2,, shall not be terminated unless one or more of the other client eligibility criteria are no longer met.

8. The client voluntarily withdraws from the waiver. The client shall be terminated from the waiver effective upon the day after the date on which the client's request is documented.

8.500.106.G The CCB shall not send the LTC notice of action form when the basis for termination is death of the client, but shall document the event in the client record. The date of action shall be the day after the date of death.

8.500.107 QUALITY ASSURANCE

8.500.107.A. The monitoring of services provided under the HCBS-SLS waiver and the health and well-being of clients shall be the responsibility of the Operating Agency, under the oversight of the Department.

8.500.107.B. The Operating Agency shall conduct on-site surveys or cause to have on-site surveys to be done in accordance with guidelines established by the Department or the Operating Agency. The survey shall include a review of applicable Operating Agency rules and regulations and standards for HCBS-SLS.

8.500.107.C The Operating Agency, shall ensure that the case management agency fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with assurances required of these programs.

8.500.107.D The Operating Agency, shall maintain or cause to be maintained, for three years, complete files of all records, documents, communications, survey results, and other materials which pertain to the operation and service delivery of the SLS waiver program.

8.500.107.E The Operating Agency shall recommend to the Department the suspension of payment denial or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

8.500.107.F After receiving the denial or termination recommendation and reviewing the supporting documentation, the Department shall take the appropriate action.

8.500.108 CLIENT PAYMENT-POST ELIGIBILITY TREATMENT OF INCOME

8.500.108.A A client who is determined to be Medicaid eligible through the application of the three hundred percent (300%) income standard at 10 CCR 2505-10 §8.1100.7, is required to pay a portion of the client's income toward the cost of the client's HCBS-SLS services after allowable income deductions.

8.500.108.B This post eligibility treatment of income (PETI) assessment shall:

1. Be calculated by the case management agency during the client's initial assessment and continued stay review for HCBS-SLS services.

2. Be recomputed, as often as needed, by the case management agency in order to ensure the client's continued eligibility for the HCBS-SLS waiver

8.500.108.C In calculating PETI assessment, the case management agency must deduct the following amounts, in the following order, from the client's total income including amounts disregarded in determining Medicaid eligibility:

1. A maintenance allowance equal to three hundred percent (300%) of the current SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of two hundred forty five dollars ($245) per month; and

2. For a client with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and

3. For a client with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate AFDC grant level; and

4. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

   a. Health insurance premiums (other than Medicare), deductibles. or coinsurance charges, (including Medicaid copayments)

   b. Necessary medical or remedial care recognized under state law but not covered under the Medicaid State Plan.

8.500.108.D Case management agencies are responsible for informing clients of their PETI obligation on a form prescribed by the Operating Agency.

8.500.108.E PETI payments and the corresponding assessment forms are due to the Operation Agency during the month following the month for which they are assessed.